APPLICATION FOR LICENSE TO OPERATE AN ASSISTED LIVING CENTER

TO: South Dakota Department of Health
Office of Health Care Facilities Licensure & Certification
615 East 4th Street
Pierre, SD 57501-1700 Telephone No. 605-773-3356 Fax No. 605-773-6667

The undersigned hereby makes application for a license to operate an assisted living center as required by SDCL 34-12

I. NAME AND LOCATION OF FACILITY

Name of Facility_____
Address of Facility_____
(Street and Number) (City)
County_____ Zip Code (9 digit)_____ Telephone No._____ Fax No._____
Mailing Address (if different from above)_____
E-Mail Address _____

II. CAPACITY AND CLASSIFICATION OF FACILITY

A. _____ Number of Beds B. Does facility request a Multiple License? [ ] Yes [ ] No
C. Approvals Requested; Please check those for which application is made:
[ ] Medication Administration [ARSD 44:04:04:12.01(2)] Inservice date _____.
[ ] Acceptance of Cognitively Impaired Residents (ARSD 44:04:04:12.01(3)] Inservice date _____.
[ ] Acceptance of Physically Impaired Residents [ARSD 44:04:04:12.01(4)]
[ ] Acceptance of Residents Incapable of Self-preservation [ARSD 44:04:04:12.01(5)]
[ ] Acceptance of Residents Dependent on Supplemental Oxygen [ARSD 44:04:04:12.01(6)]
[ ] Acceptance of Residents Requiring Therapeutic Diets [ARSD 44:04:04:12.01(7)]

III. CONTROL OF FACILITY:

A. Check below the one which applies:

[ ] Sole Proprietorship

1. If sole proprietorship, list name of owner:
_____

[ ] Partnership
[ ] Limited Liability Partnership (LLP)

2. If partnership, list name of partnership and **attach** a list of names and addresses of partners:_____
_____
_____

[ ] Corporation [ ] Non-profit [ ] Profit

3. If corporation, give name and address of corporation: Phone _____
_____
_____

4. If corporation, give state under which laws the corporation is organized:
_____

[ ] Limited Liability Company (LLC)

5. If LLC, give name of company and **attach** a list of names and addresses of members:_____

[ ] Political Subdivision (Specify):_____
[ ] Other (Specify):_____

B. Governing Body Organization:
Attach list of governing board members including profession, address, and board position.
C. Staffing:
Attach list of consultants, if applicable, including license, certification or registration and expiration date.
D. Management Group, if applicable:_____
(Organization) (Address)
E. Person in Charge Onsite_____
F. Administrator, if different from above _____
Attach proof of administrator qualifications.

G. Owner of Building:_____ Address_____
[ ] Individual; [ ] Partnership; [ ] L.L.P.; [ ] Non-profit Corporation; [ ] Profit Corporation; [ ] LLC; [ ] Political Subdivision. **Attach** list Board of Directors, if corporation; List LLC members, Partners or Individual, including profession and address, if different from B.

H. Lease: [ ] Yes [ ] No; If yes_____
(Organization) (Address)
[ ] Individual; [ ] Partnership; [ ] LLP; [ ] Non-profit Corporation; [ ] Profit Corporation; [ ] LLC; [ ] Political Subdivision. **Attach** list of Board of Directors, if corporation, List LLC members, Partners or Individual, including profession and address, if different from B.

I. **Attach** organization charts for all above that are applicable, plus copies of existing leases, subleases, management contracts or applicable supporting documentation that indicates legal sequence from ownership to actual operation of the facility. If the requested documents were submitted previously, give date:_____.

IV. BUILDING AND SERVICES

A. Complete attached list of services offered and other information

B. Address of buildings in which residents are housed _____;
Number of licensed beds in each _____; Number of Unlicensed Beds_____. Co-located Services? [ ] Yes, [ ] No; Describe_____
_____

C. Is facility engaged in or planning to build, remodel, or add a new service? Yes ____ No ____. If yes, have plans been submitted? [ ] Yes [ ] No. Anticipated date of completion _____ Scope of project _____
_____

D. Automatic sprinkler system annual inspection_____by_____
(date)

E. Do you have recalled sprinklers in the building? [ ] Yes [ ] No _____ Date replaced. _____ Date scheduled for replacement.

F. Does the facility **handle resident monies** either in excess of $50 per month for individual residents or in excess of $500 per month for all residents? [ ] Yes [ ] No;
Amount of monies handled $_____ Bond Amount $_____ Submit a copy of your surety bond.

V. APPLICANT:

I verify the information contained in this application is true and complete, and I consent to allow inspections of the assisted living center by authorized department representatives upon the presentation of identification during hours of operation.

Signed_____ Date_____
(Owner, Administrator, or other individual authorized to act on behalf of facility)

Title or Position_____

Subscribed and sworn to before me this _____ day of _____, 200_____. (Seal)

Notary Public	My commission expires:

APPLICATIONS MUST BE COMPLETE, SIGNED AND NOTARIZED TO BE PROCESSED

VI. LICENSE FEE

The license fee in the amount of $_____, ($100 plus $3 for each bed licensed) is attached to this application. Make check, money order, or postal note payable to the South Dakota Department of Health.

Note: Please submit original and retain one copy for your files. Attach all required documentation to the original application.

FOR HEALTH DEPARTMENT USE ONLY
Fee received $_____ Receipt No._____ License No._____

The department will issue or renew a license only after payment of the proper fee, ascertainment that the facts set forth in the application are true and complete, and satisfactory evidence of the applicant's ability to comply with the provisions of SDCL Chapter 34-12 and the rules promulgated thereunder.

Assisted Living Center License Application

Facility_____Address_____
(Name)

Check services offered as of the date of application:

[ ] Day Care: [ ] Child Number _____; [ ] Adult Number _____; Date Implemented _____.

[ ] Respite Program, Date Implemented _____.

[ ] Home Health Agency(ies) serving residents in your facility (List)

_____
(Agency)

_____
(Agency)

_____
(Agency)

Number of residents served by home health services _____.

[ ] Other (List)_____
_____
_____

(If services not provided directly, list name of contractor.)

I hereby authorize the Department of Health to make the list of services available to requesters unless prohibited as noted below:

_____
_____

Signature_____ Date_____